CHAPTER FOURTEEN: MENTAL HEALTH LAW

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CHAPTER FOURTEEN: MENTAL HEALTH LAW

I. INTRODUCTION

This chapter provides a very general overview of the rights of persons with mental illnesses, whether as patients inside a mental health facility or as persons outside such a facility. This discussion of mental health law is intended to provide the reader with a general framework to use for their own information or as a basis for further research. An excellent resource for further information or referrals is the Community Legal Assistance Society (CLAS). CLAS operates a mental health law program that represents individuals at hearings before the BC Criminal Code Review Board under Part XX.1 of the Mental Disorder provisions of the *Criminal Code of Canada,* and the BC Mental Health Review Board under the *Mental Health Act*, RSBC 1996, c 288 [*MHA*]. CLAS also provides legal information and identifies potential test cases. See **Chapter 23: Referrals** for CLAS' contact information.

This chapter engages with the legal issues that may arise due to a person's mental disorder. By "mental disorder", we are referring to the range of illnesses and disorders dealt with by psychiatry. It is important to keep in mind that mental illness is not the same as mental incapacity. For legal matters concerning capacity, such as the capacity to enter into a contract, make a will, or create a representation agreement, please consult **Chapter 15: Guardianship.**

For the purposes of this chapter, the most important statute is the *MHA*. Other pertinent legislation is listed later in this chapter under **Part II**: **Governing Legislation and Resources**. If you have an issue regarding a person who has come into conflict with the law and shows signs of psychiatric disturbance, you may also need to review the *Forensic Psychiatry Act*, RSBC 1996, c 156 [*FPA*]. This legislation governs the forensic psychiatry services which assist with court-ordered psychiatric assessments, including fitness to stand trial or "Not Criminally Responsible" designations.

A. Mental Health, Capacity, and the Law: An Overview

There are three distinct areas of concern at the intersection between the law, mental health, and capacity: (1) persons who suffer or have suffered from psychiatric disorders, (2) persons who have developmental disabilities, and (3) persons who have diminished capacity. These issues are considered separately below in order to direct you to the pertinent chapter. Some matters are covered in this chapter, while others are covered in **Chapter 15: Guardianship**. However, it is important to bear in mind that a client may experience several mental health challenges that overlap and blur the lines between the categories. For example, a person may have diminished cognitive capacity due to Alzheimer's in addition to an underlying schizophrenia disorder that they manage with medication.

1. Psychiatric Disorders

The first group encompasses those who may not have a developmental disability or diminished capacity, but who suffer from a psychiatric disorder. Psychiatric disorders can range from mild delusions or mood disorders, to pervasive and severe psychosis. These individuals are most likely to fall under the provisions of the *MHA*. The legal issues faced by this group are the central focus of **Chapter 14: Mental Health Law**. Therefore, in this chapter, it is important to note that the term "mental disorder" refers to psychiatric illness and not to those with developmental delays or diminished capacity.

2. Developmental Disabilities

This second category refers to people who are developmentally delayed or intellectually impaired due to genetic factors, birth trauma, or injury early in life, and who may or may not be able to live independently within the community. These individuals may not have the capacity to make legal decisions or treatment decisions. Family members should be encouraged to use the planning tools found in **Chapter 15: Guardianship** to make provisions for the care of these individuals. To plan for their financial well-being, their family members may wish to consult the **Chapter 15** section "Overview of Incapacity—Section D. Wills and Estates." However, developmental delays are not covered in depth in the LSLAP Manual. For further information regarding supports and resources for persons with developmental disabilities, please visit the following Government of British Columbia websites:

Adults with Developmental Disabilities
Website: https://www2.gov.bc.ca/gov/content/family-social-supports/services-for-people-with-disabilities/supports-services#programssupportsforadultswithdd

Transition Planning for Youth and Young Adults
Website: https://www2.gov.bc.ca/gov/content/family-social-supports/services-for-people-with-disabilities/transition-planning-for-youth-young-adults

Children & Youth with Support Needs
Website: https://www.2.gov.bc.ca/gov/content/health/managing-your-health/child-behaviour-development/support-needs

3. Cognitive Incapacity

The third area of concern includes those people who, due to disease or trauma, have become mentally incapable. It is important to note that the threshold for capacity may differ depending on the legal matter at stake—for example, there may be a different level of capacity required for the decision to appoint a Representative in a Representation Agreement than there would be for the decision to draft a will. Family members and caregivers for this group would be better served by the information in **Chapter 15: Guardianship**.

II. GOVERNING LEGISLATION AND RESOURCES

A. *Legislation*

Adult Guardianship Act, RSBC 1996, c 6 [*AGA*].

Adult Guardianship and Planning Statutes Amendment Act, S.B.C 2007, c 34 [*AGPSAA*].

Criminal Code, R.S 1985, c. C-46 (Part XX.1, Mental Disorder provisions) [*CC*]

Forensic Psychiatry Act, RSBC 1996 c 156 [*FPA*].

Health Care (Consent) and Care Facility (Admission) Act, RSBC 1996, c 181 [*HCCFA*].

Mental Health Act, RSBC 1996, c 288 [*MHA*].

Mental Health Amendment Act, S.B.C 1968, c 27 [*MHAA*].

Mental Health Regulations, B.C Reg. 233/99; O.C. 869/99; B.C. Reg. 96/2018, May 15, 2018

Patients Property Act, RSBC 1996, c 349 [*PPA*].

Power of Attorney Act, RSBC 1996, c 370 [*PAA*].

Public Guardian and Trustee Act, RSBC 1996, c 38 [*PGTA*].

Representation Agreement Act, RSBC 1996 c 405 [*RAA*]

B. *Resources*

1. *Counselling Services*

Counselling is an invaluable resource for those experiencing distress resulting from legal issues. Some counsellors may also provide integrated case management for those suffering from more severe disorders and requiring greater support.

Broadway Youth Resource Centre (BYRC)
2455 Fraser Street
Vancouver, BC V5T 0E6
Telephone: (604) 709-5720
Fax: (604) 709-5721
Email: byrc@pcrs.ca
Website: https://pcrs.ca/service-resource-centres/broadway-youth-resource-centre-2/

- Offers counselling and support services in areas of youth and family, anger management, addiction, housing, employment, sexual orientation and/or gender identity. These services are offered without charge.

Oak Counselling Services Society
949 West 49th Avenue
Vancouver, BC V5Z 2T1
Voicemail: (604)-266-5611
Fax: (604) 261-7205
Email: info@oakcounselling.org
Website: www.oakcounselling.org

- Offers professionally supervised counselling for issues such as grief, relationships, and life transitions. Fees are based on a sliding scale, ranging from $10–$65 per session.

Other Counselling Options
Website: https://willowtreecounselling.ca/wp-content/themes/willowtree/reduced-cost-counselling.pdf

- This PDF provides an excellent list of options for reduced cost counselling services, compiled by Megan Sutherland of Willow Tree Counselling (https://willowtreecounselling.ca/).

2. *Advocacy Resources*

Access Pro Bono (Greater Vancouver and Victoria)
300 – 845 Cambie St
Vancouver, BC V6B 4Z9
Website: www.accessprobono.ca/
Toll-free: 1-877-762-6664

- Provides advice on rights pertaining to mental health law upon appointment.
- May be available for *habeas corpus* applications, section 33 applications under the *MHA*, as well as applications for judicial review of Mental Health Review Board hearing decisions.

Peer Navigator Program (Canadian Mental Health Association)
110 – 2425 Quebec St
Vancouver, BC V5T 4L6
Email: peer.navigator@cmha.bc.ca
Website: www.vancouver-fraser.cmha.bc.ca/
Telephone: (604) 872-3148

- Provides peer-based support on a wide breadth of issues surrounding mental health, housing, income assistance, legal aid and community connections.

Disability Alliance BC
1450-605 Robson St
Vancouver, BC V6B 5J3
Website: https://disabilityalliancebc.org/
TTY: (604) 875-8835
Toll-free: 1-800-663-1278

- A self-help umbrella group that raises public awareness about issues affecting people with disabilities.
- Their Disability Law Clinic (DLC) Legal Services program provides free and confidential summary advice and referral services on issues pertaining to accessibility laws, discrimination/human rights, access to services, and accommodation in the workplace.
- A great resource for people with any type of disability (mental or physical) that can provide assistance with a wide range of legal and non-legal issues.
- Clients should contact the Advocacy Access number, provided above.

B.C Human Rights Clinic (CLAS)
1140 West Pender St
Vancouver, BC V6E 4G1
Website: https://bchrc.net/
Telephone: (604) 622-1100
Toll-free: 1-855-685-6222
Fax: (604) 685-7611

- Provides informational services and an advocacy program to protect human rights and prevent discrimination.

Community Legal Assistance Society (CLAS)'s Mental Health Law Program
1140 West Pender St
Vancouver, BC V6E 4G1
Website: www.clasbc.net/
Telephone: (604) 685-3425
Fax: (604) 685-7611

- Provides representation for involuntarily detained patients who have tribunal hearings either under the *MHA* or the mental disorder provisions of the Criminal Code. Other CLAS programs provide free legal services in areas such as housing, workers' rights, E.I., sexual harassment in the workplace, and human rights.

COAST Foundation Society
293 East 11th Ave
Vancouver, BC V5T 2C4
Email: info@coastmentalhealth.com
Website: www.coastmentalhealth.com
Telephone: (604) 872-3502
Toll-Free: 1-877-602-6278
Fax: 604-879-2363

- Provides a variety of mental health services, including a mental health resource centre and community or shared housing options.

Crisis Centre of Greater Vancouver
Website: https://crisiscentre.bc.ca/
Toll-free: 1-800-SUICIDE (784-2433)
Telephone: (604) 872-3311

- 24-hour hotline that provides emotional support for clients in distress and refers them to other resources for food, shelter, counselling, and legal advice. **Please note this is not a counselling hotline.**

Kettle Friendship Society
1725 Venables Street.
Vancouver, BC V5L 2H3
Website: www.thekettle.ca
Telephone: (604) 251-2801
Fax: 604-251-6354

- A non-profit agency providing support and services to those suffering from mental illness. Services include housing assistance, employment advocacy, and an on-site health clinic.

Legal Aid BC
400-510 Burrard St
Vancouver, BC V6C 3A8
Website: www.legalaid.bc.ca/
Telephone: (604)-408-2172
Toll-free:1-866-577-2525

- May be available for *habeas corpus* applications, section 33 applications under the *MHA*, as well as applications for judicial review of Mental Health Review Board hearing decisions. The request for assistance in these areas would go through the Legal Aid appeals department.

Motivation, Power, and Achievement Society (MPA)
122 Powell St
Vancouver, BC V6A 1G1
Website: www.mpa-society.org
Telephone: (604) 482-3700
Fax: (604) 738-4132
Court Services: (604) 688-3417

- Offers information, counselling, and representation for Review Panels.

- The Court Services Program assists clients who have a mental health disability during the criminal court process. Clients may also be assisted following court appearances (e.g., with bail or probation orders).

Nidus Personal Planning Resource Centre and Registry
Website: https://www.nidus.ca/

- A non-profit organization that provides information about personal planning, specializing in Representation Agreements, and operates a centralized Registry for personal planning documents.
- Website includes self-help guides and templates.

3. *Government Resources*

British Columbia Review Board
Website: http://www.bcrb.ca
Telephone: (604) 660-8789
Toll-Free: 1-877-305-2277
Fax: (604) 660-8809

- Makes review dispositions where individuals charged with criminal offences have been given verdicts of "Not Criminally Responsible" (NCR) on account of mental disorder or "Unfit to Stand Trial" UST on account of mental disorder, by a court.

Canadian Mental Health Association, BC Division
905-1130 West Pender St
Vancouver, BC V6E 4A4
Email: info@cmha.bc.ca
Website: www.cmha.bc.ca/
Telephone: (604) 688-3234
Toll-free: 1-800-555-8222
Fax: (604) 688-3236

- Provides recovery-focused programs and services to promote good mental health and includes resources for youth and adults.

Department of Justice
Website: https://www.justice.gc.ca/eng/

- The Department of Justice website contains all federal statutes, information about the Canadian justice system, and links to related websites.

Guide to the Mental Health Act
Website: https://www.health.gov.bc.ca/library/publications/year/2005/guide-mental-health-act.pdf

- Provides plain-language explanations regarding the *MHA* and its implications for those who are impacted by it.

Representing Clients Impacted by Coercive Mental Health and Substance Use Health Laws: Legal Research and Resource Guide
Website: https://www.healthjustice.ca/for-lawyers-legal-advocates

- A guide by Health Justice that provides an overview of legal research and resources for lawyers and advocates to represent affected clients.
- Downloadable PDF is available at the above link.

Mental Health Review Board
Website: https://www.bcmhrb.ca/ Telephone: (604) 660-2325

- Responsible for conducting reviews of involuntarily admitted patients under the *MHA*. Their website provides frequently asked questions, rules, and other helpful links.

Ministry of Health Services
Website: https://www2.gov.bc.ca/gov/content/health/health-forms/mental-health-forms

- Downloadable *MHA* forms are available on their website.

Public Guardian and Trustee of BC (PGT)
700-808 West Hastings St Telephone: (604) 660-4444
Vancouver, BC V6C 3L3 Fax: (604) 660-0374
Website: http://www.trustee.bc.ca

- An independent, impartial public official and Officer of the Court who serves to balance protection with autonomy and to ensure that people may live as they choose with the support of family and friends.
- Offers **Child and Youth Services**; namely, upholds and protects the rights of those under the age of 19 by reviewing all personal injury settlements, legal contracts, trusts and estates involving minors, and by ensuring that children are properly represented in all legal matters.
- Acts as guardian of estate for children who are in provincial government care and for those undergoing adoption.
- **Services to Adults** are primarily to uphold the rights of adults who are unable to manage their own affairs. This role includes helping them with financial and legal matters and supporting their lifestyle and health care decisions.
- **Estate Administration** settles the estates of deceased persons when there is no named executor or when there is no one willing or able to act as executor. This includes securing assets, settling debts and claims against the estate, and identifying and locating heirs and beneficiaries

Planned Lifetime Advocacy Network (PLAN)
205-175 East Broadway St Telephone: (604) 439-9566
Vancouver, BC V5T 1W2 Fax: (604) 439-7001
Website: www.plan.ca

- Provides advocacy services and up-to-date legal information on wills and estates, trustees, and financial planning. PLAN also works with families in developing personal support networks for relatives with disabilities and provides advocacy and monitoring services for families whose parents have passed away.

Representative for Children and Youth (RCYBC)
Website: https://rcybc.ca Telephone: 1-800-476-3933

- Supports children, youth, and some young adults receiving services or programs provided for or funded by the government, including addiction services, mental health services, and children and youth with special needs.

Vancouver Access & Assessment Centre (AAC)
Website: http://www.vch.ca/locations-services/result?res_id=1186

Telephone: 1-604-675-3700

- Located at Vancouver General Hospital, the AAC offers short term treatment on-site, by telephone, and by mobile response. Clinical staff, including registered nurses, social workers, and psychiatrists, provide 24/7 support, stabilization, and crisis management to clients.

III. THEORY AND APPROACH TO MENTAL HEALTH LAW

Admission to a mental health facility can significantly impact an individual's ability to exercise their rights. Textbooks have advocated for a functional approach to mental health law, encouraging courts to consider solely how the disability may relate to the specific issue brought before them. Incapacity in one area does not necessarily mean incapacity in all areas. Most mental health legislation, however, is over-inclusive and therefore impairs the rights of mentally ill persons in areas where they might have the mental capacity to act for themselves. The common law tests for capacity can be found in **Chapter 15: Adult Guardianship**.

Section 15(1) of the *Canadian Charter of Rights and Freedoms* [*Charter*] has made it easier to preserve the rights of those affected by mental health law. While most discriminatory legislation in BC remains unchallenged, the *MHA* "deemed consent provisions" and the *HCCFA* and *Representation Agreement Act* [*RAA*] "substitute decision making" provisions, was challenged as unconstitutional at the BC Supreme Court (see *MacLaren v British Columbia (Attorney General)*, 2018 BCSC 1753). The Attorney General of BC raised the issue of public interest standing in the above case which resulted in the case being dismissed. This decision was appealed to the BC Court of Appeal and the appeal was allowed on the issue of public interest standing in favour of the Council of Canadians with Disabilities (see *Council of Canadians with Disabilities v British Columbia (Attorney General)*, 2020 BCCA 241). The Attorney General of BC applied for leave to appeal to the Supreme Court of Canada, and the Supreme Court of Canada heard the appeal January 13, 2022. The Supreme Court of Canada released its decision on June 23, 2022. The SCC has held that the Council of Canadians with Disabilities has the standing to challenge the constitutionality of the legislation (see *British Columbia (Attorney General) v Council of Canadians with Disabilities* 2022 SCC 27). However, this litigation is still ongoing and will take time to resolve.

All *Charter* challenges have been directed towards either the *MHA*, the *HCCFA*, or the *Criminal Code*. The Community Legal Assistance Society may be able to assist with serious *Charter* challenges, including test litigation.

IV. LEGAL RIGHTS AND MENTAL HEALTH LAW

A. Income Assistance

Mentally ill persons may be eligible for benefits under the "Persons with Disabilities" (PWD) or "Persons with Persistent and Multiple Barriers to Employment" (PPMB) designations. Qualification requirements are strict, but decisions concerning eligibility can be negotiated with the Ministry of Employment and Income Assistance, and, if need be, appealed. Generally, a doctor must fill out a specific form indicating that the person qualifies. Disability Alliance BC assists with applications and appeals (for further details see **Chapter 21: Welfare Law**). There may be strict deadlines for these applications, so it is important to avoid delay in these cases.

B. Employment/Disability Income

If a person cannot work because of mental health issues, the person may be entitled to employment insurance, disability benefits, CPP disability benefits, or WCB benefits if the mental illness is work-related. For information on CPP disability benefits, see **Section IV.D: Canada Pension Plan**, below. Please be advised that there are strict time limits involved when applying for these benefits.

If a person is hospitalized in a psychiatric facility because of an injury at work, they may be eligible for WCB benefits. Please contact the Workers Advisory Group through CLAS for more information or refer to **Chapter 7**: **Workers' Compensation**.

C. Employment Insurance

Individuals who are voluntarily or involuntarily admitted to a psychiatric facility may still be eligible to collect Employment Insurance benefits. However, the *Employment Insurance Act*, SC 1996, c 23 is a complex piece of legislation detailing numerous requirements to qualify for benefits (e.g. number of hours worked, previous claims, unemployment rate, etc.). If a person is denied benefits, it is best to consult a lawyer with specific expertise in these areas (e.g., CLAS). Be aware that there may be strict timelines in applying for benefits or appealing a denial of benefits. For more information, please consult **Chapter 8: Employment Insurance.**

D. Canada Pension Plan

Long-term patients may apply for disability pensions. A claim takes four or five months to process. Hospitalization does not affect a person's right to collect a pension, and it is possible to receive CPP benefits for periods of hospitalization. Disability Alliance BC assists people with these applications if they reside in the community. Those who are hospitalized should contact the hospital social worker to assist with these applications as soon as possible, as strict time limits may apply.

E. Driving

A mental disorder does not automatically disqualify a person from driving. The Superintendent of Motor Vehicles—or a person authorized by the Superintendent—has the discretion to deny licences to those deemed "unfit" under section 92 of the *Motor Vehicle Act*, RSBC 1996, c 318. This decision is based on the Canadian Council of Motor Transport Administrators (CCMTA) Medical Standards with BC Specific Guidelines (available online at: https://www2.gov.bc.ca/gov/content/transportation/driving-and-cycling/roadsafetybc/medical-fitness/medical-prof/med-standards). Each section describes the medical condition(s) under evaluation, the potential effect of the condition(s) on driving ability, and guidelines for assessing driving ability.

Chapter 6 of the Guidelines discusses cognitive impairment (including dementia), while Chapter 14 addresses psychiatric disorders. The national standard allows those with psychiatric disorders to hold a license if their condition is stable, if they possess the insight to stop driving if their condition worsens, and if the faculties required to drive safely are not impaired. The BC Guidelines add that RoadSafetyBC can request a Driver's Medical Examination Report and additional medical information from the individual's doctor or mental health team. The Guidelines also set out the conditions for maintaining a license, for reassessment if a license is lost, and the information that will be sought from health care providers during an assessment.

It is important to note that individuals who have been hospitalized due to a mental health issue must stop driving and report to RoadSafetyBC. Those who suffer a psychotic episode may have to undergo annual re-assessment until their doctor reports that the episodes have abated enough to resume driving. While assessments must rely primarily on clinical evaluations, re-assessment intervals may be determined on an individual basis by RoadSafetyBC. The assessment guidelines, as well as their rationale, can be reviewed online at https://www2.gov.bc.ca/gov/content/transportation/driving-and-cycling/roadsafetybc/medical-fitness/medical-prof/med-standards/14-psychiatric#14.6.1.

A review of a driver medical fitness decision can be requested at no cost in the event that a medical condition has changed or improved. RoadSafetyBC's adjudicator or a nurse case manager will consider any information provided, but an up-to-date medical assessment from a physician is required.

F. The Right to Vote

Both voluntary and involuntary patients in mental health facilities have the right to vote. This has been the case since *Canada (Canadian Disability Rights Council) v Canada* (1988), 3 FC 622, where it was decided that a person is not disqualified from voting on the basis that a committee has been appointed for them. Polling stations are normally set up at long-term psychiatric care facilities. Because enumeration takes place at the facility, patients must vote in the riding where the hospital is located.

G. Human Rights Legislation

Under both provincial and federal human rights legislation, it is illegal to discriminate against a person in the protected areas of housing/tenancy, employment, or services customarily available to the public on the basis of mental illness. For information on launching a human rights complaint see **Chapter 6: Human Rights**.

H. Civil Responsibility

In general, mental incompetence or disability is not a defence to an action for intentional tort or negligence. However, where a certain amount of intent or malice is required for liability, the fact that the defendant lacked full capacity to understand what they were doing may relieve them of liability. A defendant lacking the ability to control their actions will not be liable. Involuntary actions do not incur liability. Anyone responsible for the care of a mentally ill person may be held responsible if the plaintiff proves a failure to take proper care supervising the person.

In civil suits, a guardian *ad litem* may be appointed with permission of the court (can be petitioned by a lawyer) to start or defend an action where a mentally ill person is a party and lacks the capacity to commence or defend that action. A person involuntarily detained under the *MHA* appears to meet the definition in the BC Supreme Court *Rules of Court* of a person under a legal disability for filing or defending a court action. Therefore, the person would need to proceed through a guardian *ad*

litem. The guardian *ad litem* could be a friend or a relative of the person, an organization, or another individual chosen and appointed by the court.

Additionally, any person found not criminally responsible by reason of a mental disorder (NCRMD) under the *Criminal Code* may not be liable for damages as a result of the offence.

I. Immigration and Citizenship

Section 38 of the *Immigration and Refugee Protection Act* [*IRPA*] deals with inadmissibility on health-related grounds. Pursuant to section 38(1)(c), foreign nationals will be inadmissible if they "might reasonably be expected to cause excessive demand on health or social services." This rule could present a bar to admission for individuals determined to be developmentally delayed or those with a history of mental illness.

However, section 38(2) lists certain exceptions. If a person may be classified as (a) a member of the family class and the spouse, a common-law spouse, or a child of a sponsor; (b) a refugee or a person in similar circumstances; (c) a protected person, or (d) where prescribed by regulation, one of their family members, that person will be exempted from the rule under section 38(1)(c).

Section 38(b) of the *IRPA* sets out that another bar to admission is the likelihood that a health condition could cause danger to public safety. Unlike section 38(1)(c), this provision is not subject to the exemptions under section 38(2). According to guidance used by IRCC staff, mental health conditions are considered likely to cause danger to public safety when they involve uncontrolled or uncontrollable elements, such as:

- Certain impulsive sociopathic behaviour disorders;
- Some aberrant sexual disorders such as paedophilia;
- Certain paranoid states or some organic brain syndromes associated with violence or Risk of harm to others;
- Applicants with substance abuse leading to antisocial behaviours such as violence, and impaired driving; and
- Other types of hostile, disruptive behaviour.

This definitions, and others, can be sourced from the IRCC website: https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/operational-bulletins-manuals/standard-requirements/medical-requirements/definitions.html.

J. The Charter

Sections 7 (the right to liberty), 9 (the right to protection against arbitrary detention), and 15 (the equality provision) of the *Charter* are particularly critical for protecting the rights of the mentally ill. The legal rights protection provisions may also be applicable, including section 12, which concerns cruel and unusual punishment.

The following decisions reflect the way that *Charter* rights have been considered when they conflict with provincial legislation regarding mental health.

Fleming v Reid, (1991) OR (2d) 169 at paras 52–59 addressed the impact of section 7 on provisions of Ontario's mental health legislation. Mentally competent involuntary patients refused treatment despite their doctors' opinion that treatment would be in their best interests. The impugned provision of Ontario's *Mental Health Act*, RSO 1980, c 262 allowed a Review Board to override treatment refusals issued by a substitute consent-giver based on the patient's prior competent wishes. The Court held that this provision violated the right to security of the person and was not in accordance

with the principles of fundamental justice. However, the disposition of this case has not influenced the application of BC's mental health legislation to date.

In *Mazzei v British Columbia (Director of Adult Forensic Psychiatric)*, 2006 SCC 7 at paras 46–47 [*Mazzei*], it was decided that the Review Boards under the Part XX.1, Mental Disorder provisions of the *Criminal Code of Canada* have the power to issue binding orders to parties other than the accused. This power can be exercised on the director of a hospital who is party to the proceedings; although the Review Board cannot dictate a specific treatment, it can impose conditions regarding treatment. This power was granted to ensure that treatments are culturally appropriate. In *Mazzei*, conditions were imposed regarding drug and alcohol rehabilitation to ensure that the process was appropriately adjusted to the individual's First Nations' ancestry.

A more recent Supreme Court decision, *R v Conway*, 2010 SCC 22 at para 78 [*Conway*] responded to the issue of whether the Ontario Review Board (ORB) under the Mental Disorder provisions of the Criminal Code, has the authority to grant remedies under section 24(1) of the *Charter*. The challenge was brought by Paul Conway, an individual found not responsible by reason of a mental disorder in 1983. He argued that his treatment and detention violated his *Charter* rights, and therefore entitled him to an absolute discharge. The Supreme Court developed a test to determine whether an administrative tribunal is authorized to grant *Charter* remedies. The Supreme Court ruled that pursuant to section 24(1), the ORB is a "court of competent jurisdiction", but that an absolute discharge was not a remedy that could be granted by the ORB under that particular circumstance. Ultimately, the *Conway* decision affirms the application of the *Charter* to administrative tribunals, including the *Criminal Code* of Canada*, Part XX.1 (Mental disorder provisions)* provincial Review Boards, which includes the British Columbia Review Board (BCRB). However, this decision limits the scope of available remedies under section 24(1) to those that have been specifically granted to a given body by the legislature. In *Conway*, the Review Board could make a determination that the provision was unconstitutional but did not have the authority to strike it down.

A case in which CLAS acted as an intervener—*Canada (Attorney General) v Downtown Eastside Sex Workers United Against Violence Society,* 2012 SCC 45 at paras 73–74—opened the door for groups of individuals to bring *Charter* challenges. In this case, sex workers were granted public standing as a group to bring *Charter* challenges. This decision impacts mentally ill people as well by enabling patients that are detained in mental health facilities to bring *Charter* challenges as a group, rather than being forced to do so on an individual basis. Additionally, organizations can begin an action on behalf of a group of vulnerable people if there is no other way for the issue to be brought before a court.

K. Legal Rights of Those in Group Homes

Throughout the greater Vancouver area, there are many group homes run by and/or for mentally ill persons who do not require confinement in a provincial mental health facility. Additionally, "Supportive Apartments" are a new tool that the provincial government has been using. These homes, run by groups such as COAST and the Motivation, Power, and Achievement Society (MPA), are governed by the *Community Care and Assisted Living Act*, SBC 2002, c 75. Foster homes and group homes of the provincial government fall under different Acts: the *Child, Family and Community Service Act*, RSBC 1996, c 46 and the *Hospital Act*, RSBC 1996, c 200.

These types of homes have some interesting interactions with the *Residential Tenancy Act*, in that they may or may not be covered on a case-by-case basis. Because there is no definitive answer at this time, individuals in group homes with tenancy issues should contact CLAS or seek other legal assistance.

Municipalities often place restrictions on the location of group homes. A Winnipeg bylaw requiring a minimum distance between group homes was struck down for violating section 15 of the *Charter* (*Alcoholism Foundation of Manitoba v The City of Winnipeg* (1990), 69 DLR (4th) 697).

V. PATIENT ADMISSION: GENERAL INFORMATION

Admissions to mental health facilities under the BC provincial *MHA* may be either voluntary under section 20 or involuntary under section 22 (see **Section VII** below). Involuntary admission under the *MHA* involves doctors renewing the patients' involuntary admittance status on a regular basis.

Admission can also occur due to a verdict of "Not Criminally Responsible by reason of Mental Disorder" or "Unfit to Stand Trial" for criminal charges, under the Mental Disorder provisions, *Part XX.1*, *Criminal Code [CC]*. This is not considered an involuntary admission under the *MHA*, but rather an NCRMD or UST admission under the CC. NCRMD and UST will see matters of treatment and release governed by a British Columbia Review Board (BCRB), governed by the Mental Disorder provisions.

Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181 [*HCCFA*] came into force on November 4, 2019, and it outlines the regulations for admission to a care facility. No person is to be admitted unless they have given consent, substitute consent (by a personal guardian with authority or person otherwise designated by the act) has been given, or the person is admitted on an emergency basis under section 24. Section 25(1) of the *HCCFA* states that if a person in care is capable and expresses a desire to leave—or they are incapable, and the person authorized to act as their substitute expresses a desire for them to leave—a manager must not prevent them from leaving.

It should be noted that patients who are initially admitted voluntarily may later have their status changed to involuntary using the admission procedure for involuntary patients. This procedure is described later in this chapter.

A. Charges for Mental Health Services

Section 4 of the *Mental Health Regulations* (BC Reg 233/99) [*MHR*] provides a formula for calculating the charges for care of persons admitted voluntarily (*MHA*, s 20) to a mental health facility. The formula is calculated by adding the daily Old Age Security maximum to the daily Guaranteed Income Supplement and multiplying by 85%.

This provision does not authorize or identify any charges for care to be paid by those persons who are admitted involuntarily (*MHA*, s 22). According to *Director of Riverview Hospital v Andrzejewski* (1983), 150 DLR (3d) 535 (BC County Court), section 11 of the *MHA* does not authorize any charges for mental health services where an individual is admitted involuntarily. Please review the *Mental Health Regulations* to determine the authorized charges for different classes of patients (i.e., voluntary and involuntary).

B. Consent to Treatment

Psychiatric treatment is legally considered a type of medical treatment. The *HCCFA* sets out the requirements for consent from the patient before a health care provider can legally provide health care. Generally, adults are presumed to be capable of consenting to treatment, and they have the right to give or refuse consent to treatment. However, there are significant exceptions in the realm of mental health or psychiatric treatment.

The *HCCFA* does not apply to the provision of psychiatric treatment where an individual is involuntarily detained under the *MHA* and/or is on leave from a psychiatric facility or has been transferred to an approved home (*HCCFA*, s 2). For those individuals, the director of the relevant psychiatric facility has the right to consent to psychiatric care on the involuntarily detained patient's behalf (see **Section VII** below). Additionally, for patients not involuntarily admitted, section 12(1) of the *HCCFA* allows an adult to be treated without their consent in an emergency situation in order to preserve that adult's life, to prevent serious mental or physical harm, or to alleviate severe pain if certain other conditions are met.

VI. MENTAL HEALTH ACT: CONSENT TO MEDICAL TREATMENT

The following subsections apply **only** to patients voluntarily admitted to a mental health facility or voluntarily receiving treatment from a health care/psychiatric service provider. Patients admitted involuntarily lose certain rights (see **Section VII** below).

A. Adult's Right to Consent

Every adult is presumed to be capable of giving, refusing, or revoking consent to health care and to their presence at a care facility (*HCCFA*, s 3).

Every adult who is capable has the right to give, refuse, and revoke consent on any grounds (including moral and religious), even if refusal will result in death (*HCCFA*, s 4).

Every adult who is capable has the right to be involved to the greatest degree possible in all case planning and decision making (*HCCFA*, s 4).

B. Care Provider's Duty to Obtain Consent

A health care provider must not provide health care to an adult without consent, except in an emergency situation or when substitute consent has been given and the care provider has made every reasonable effort to obtain a decision from the adult (*HCCFA*, ss 5, 12).

For consent to be valid, it must be related to the proposed health care, voluntary, not obtained by fraud or misrepresentation, informed (see *HCCFA*, s 6(e)), and consent must be given after an opportunity to make inquiries about the procedure (*HCCFA*, s 6).

C. Emergency Situations

A care provider may provide care to an adult without the adult's consent in an emergency situation where the adult cannot give or refuse consent, and where no personal guardian or representative is present (*HCCFA*, s 12). If a personal guardian or representative later becomes available and refuses consent, the care must stop (*HCCFA*, s 12(3)).

However, the above does not apply if the care provider has reasonable grounds to believe that the adult, while capable and after attaining 19 years of age, has expressed an instruction or wish applicable to the circumstances to refuse consent to the health care (*HCCFA*, s 12.1).

D. Personal Guardians and Temporary Substitute Decision Makers

A care provider may provide care to an adult without the adult's consent if the adult is incapable of giving or refusing consent and if a personal guardian or representative gives consent (*HCCFA*, s 11).

If a personal guardian or representative refuses to consent, the health care may be provided despite the refusal in an emergency if the person refusing consent did not comply with their duties under the *HCCFA* or any other act (*HCCFA*, s 12.2).

A temporary substitute decision maker (TSDM) can be chosen by the care provider in accordance with section 16 of the *HCCFA*. See sections 16-19 of the *HCCFA* for the authority and duties of a TSDM. There is a statutory list of those assigned to be a TSDM, beginning with a spouse and moving down. More details can be found in **Chapter 15: Adult Guardianship.**

In circumstances where a mentally ill person is judged to be incapable of making a health care decision, the provisions for a substitute decision maker under the *HCCFA* continue to apply. However, if the person is declared an involuntary patient under section 22 of the *MHA*, then psychiatric treatment can be provided under the deemed consent provisions of section 32 of the *MHA*.

E. Consent to Treatment Forms

When admitted to a mental health facility, voluntary patients (or their committees, parents, guardians, or representatives) may be asked to sign a "consent to treatment" form, which purports to "authorize the following treatment(s)". There is no basis in law for requiring this form be signed as a prerequisite of a voluntary admission, but the law does not prohibit such a requirement.

Under the HCCFA, "An adult consents to health care if

(a) the consent relates to the proposed health care,
(b) the consent is given voluntarily,
(c) the consent is not obtained by fraud or misrepresentation,
(d) the adult is capable of making a decision about whether to give or refuse consent to the proposed health care,
(e) the health care provider gives the adult the information a reasonable person would require to understand the proposed health care and to make a decision, including information about
    (i) the condition for which the health care is proposed,
    (ii) the nature of the proposed health care,
    (iii) the risks and benefits of the proposed health care that a reasonable person would expect to be told about, and
    (iv) alternative courses of health care, and
(f) the adult has an opportunity to ask questions and receive answers about the proposed health care." (s 6).

Consent can be given in writing, orally, or inferred from conduct.

1. Refusal to Sign Consent Treatment Form: Possible Consequences

A person who refuses to sign the consent form may be deemed a patient who "could not be cared for or treated appropriately in the facility" under section 18(b) of the *MHA*. This person runs the risk of being refused admission to the facility or being discharged if already admitted.

Under the *Patients Property Act* (*PPA*), hospitals could circumvent the issue of consent by seeking a court order, supported by two medical opinions, to have the patient declared incapable of managing their personal affairs. Minor changes were made to the *PPA* in September 2011. Under the *PPA*, a legal guardian or public trustee is appointed as a committee to give consent on behalf of the patient. It is not sufficient for a family member to give consent for a voluntary informal patient without first obtaining legal guardianship or committeeship, or becoming a Representative under the *Representative Agreement Act*, or becoming a substitute decision maker under the *HCCFA*.

A decision from Nova Scotia regarding guardianship found that some of the central provisions of the *Incompetent Persons Act*, RSNS, 1989, c 218 are unconstitutional (*Webb v Webb*, 2016 NSSC 180 at paras 19–22). This legislation allows for the appointment of a guardian where a person is found incompetent (similarly to the *PPA*), but it was found that the legislation was overbroad. It did not allow a court to tailor a guardianship order so that a person subject to that order could retain the ability to makes

decisions in respect of those areas in which they are capable. This may have an impact on the application of BC's *PPA* in the future.

Sections 50 to 59 of the *Adult Guardianship Act*, RSBC 1996, c 6 [*AGA*] allow for a person from a designated agency to make unilateral decisions which affect the adult's support and assistance without their consent, including treatment and removal from a residence. For instance, section 56 allows a person from a designated agency to apply for a court order which can determine an adult's mode of treatment. Furthermore, section 59 gives a person from a designated agency broad powers , such as the power to enter their premises without a warrant, to remove them from their premises and convey them to "a safe place", and to provide emergency medical care. This is permitted so long as these powers are exercised within the context of an emergency situation or a context where the adult is incapable of providing consent. See **Chapter 15: Adult Guardianship** for more information.

The facility could also proceed under the *HCCFA* by declaring the patient incapable of consenting, by using a TSDM, and/or by claiming that a state of emergency exists, such that the patient must be treated without their consent.

VII. MENTAL HEALTH ACT: INVOLUNTARILY ADMITTED PATIENTS

Patients who are admitted to a mental health facility without their consent are admitted involuntarily. The *MHA* provides mechanisms for both short-term emergency admissions and long-term admissions. The *HCCFA* or the *Representation Agreement Act* and all of their requirements regarding consent to treatment do not apply to the psychiatric treatment of involuntarily admitted patients. Involuntarily admitted patients, therefore, have few legislative rights. However, some provisions of the *MHA* could be challenged under the *Charter*, such as the current CLAS challenge in BC to the "deemed consent" provisions of the BC *Mental Health Act* (see *MacLaren v British Columbia (Attorney General)*, 2018 BCSC 1753). The Attorney General of BC raised the issue of public interest standing in the above case which resulted in the case being dismissed. This decision was appealed to the BC Court of Appeal and the appeal was allowed on the issue of public interest standing in favour of the Council of Canadians with Disabilities (see *Council of Canadians with Disabilities v British Columbia (Attorney General)* 2020 BCCA 241). The Attorney General of BC applied for leave to appeal to the Supreme Court of Canada, and the Supreme Court of Canada heard the appeal January 13, 2022. The Supreme Court of Canada released its decision on June 23, 2022. They held that the appeal should be dismissed and awarded special costs on a full indemnity basis to the respondent throughout. The order of the Court of Appeal remitting the question of the respondent's public interest standing to the Supreme Court of British Columbia was set aside and standing was granted to the respondent (see *British Columbia (Attorney General) v Council of Canadians with Disabilities*, 2022 SCC 27).

A similar challenge occurred in Ontario, in *PS v Ontario*, 2014 ONCA 900. The constitutionality of the provisions of the *Mental Health Act*, R.S.O. 1990, c. M.7, which provided for involuntary committal of long-term detainees, were challenged and found to violate section 7 of the *Charter*. The judgement stated that during an involuntary detention, the patient must be provided meaningful procedural avenues to seek the accommodation and treatment they need to be rehabilitated. It was determined that the province does not have the power to detain mental health patients indefinitely where such procedural protections are absent. This will likely change the role patients themselves play in determining the course and nature of their treatment in Ontario. It is unclear at this stage what effect this Ontario case may have in British Columbia.

A recent case in British Columbia, *AH v Fraser Health Authority*, 2019 BCSC 227, clarified the procedures for detention under amendments to the *AGA*. It found that the Fraser Health Authority's detention of A.H. of nearly a year was not an "emergency measure", as laid out in s 59(2)(e) of the *AGA*, and that such detentions should not last longer than is necessary to apply for a support and assistance order from the Provincial Court.

Section 22 of the *MHA* provides that a person may be admitted involuntarily and detained for up to 48 hours on the completion of one involuntary patient certificate (Form 4—BC *MHR*). The person must first be examined by a doctor, and the doctor must provide a medical certificate stating that they are of the opinion that the person has a mental disorder and requires treatment to prevent "the substantial mental or physical deterioration" of the person or to protect that person or others. A second doctor must provide a second certificate if the person is to be detained for longer than the initial 48 hours. The leading case in this area, *Mullins v Levy* 2009 BCCA 6 [*Levy*] at paras 105–110, , applied a broad definition of "examination" and stated that the *MHA* does not require a personal interview of the patient in every instance. However, a patient is entitled to request a Review Panel hearing after the second certificate is completed, in accordance with section 25 of the *MHA*. The involuntary detention can be renewed for one-, three-, and subsequent six-month periods. The involuntarily detained patient has a right to apply for a Review Panel hearing within each renewal period.

When the patient is re-evaluated, the facility must determine whether the involuntary admission criteria still apply and whether there is a significant risk that, if the patient is discharged, they will be unable to follow the prescribed treatment plan and be involuntarily admitted again in the future.

The *MHA* also potentially allows involuntarily committed patients to be granted leave or extended leave under certain conditions, as authorized by their doctor. This means that the patient may be permitted to live outside of the facility, but they will still be considered to be involuntarily committed and will remain subject to the provisions of the *MHA*.

The Mental Health Law Program (MHLP) at CLAS assists involuntarily admitted patients at Mental Health Review Board (Review Panel) hearings. Since 2017, the Attorney General has agreed to fund representation for all involuntarily detained patients who cannot afford counsel at their Review Panel hearings. If CLAS is unavailable to make these representations, they have a roster of contracted lawyers who may provide counsel. Access Pro Bono also provides telephone assistance for people who are facing involuntary detention and seeking information about their rights under the *MHA*.

A. Restraint and Seclusion While Detained Under the MHA

British Columbia's *MHA* is silent on the issues of restraint and seclusion. Section 32 merely provides that every patient detained under the *MHA* is subject to the discipline of the director and staff members of the designated facility. Issues surrounding restraint and seclusion have yet to be thoroughly considered in BC, and there are few cases in Canada that address them. In *Levy*, the plaintiff sued a hospital and its staff for negligence, false imprisonment, and battery after he was detained and medicated for five days against his wishes when doctors decided he required treatment for mania. Although the plaintiff also argued that his *Charter* rights were violated, and he challenged the *MHA* and the *HCCFA* as unconstitutional, the Court did not rule on the *Charter* arguments. The plaintiff's claim was denied at the BCCA on factual grounds, and the Supreme Court declined to hear his appeal.

This leaves the patient's rights in the hands of facility policymakers. Such policy focuses on the benefits that seclusion may give to a patient for treatment purposes and regard is given to the safety of hospital staff. The uncertainty of the law in this area, combined with a serious potential for the deprivation of patients' rights, leaves open the possibility of a *Charter* argument to uphold patients' rights in the future.

B. Short-Term and Emergency Admissions

A person may be detained in a psychiatric facility upon the receipt of one medical certificate signed by a physician (*MHA*, s 22(1)). Such involuntary confinement can last for a maximum of 48 hours for the purposes of examination and treatment. A second medical certificate from another physician is required to detain the patient for longer than 48 hours (*MHA*, s 22(2)). As an alternative to the admissions criteria under the *MHA*, a patient may be given emergency treatment under section 12 of the *HCCFA* if they have not been involuntarily admitted. As of November 4, 2019, a person can also be admitted in the case of emergencies under section 24 of the *HCCFA*.

1. Authority of a Police Officer

If a police officer believes a person has an apparent mental disorder and is acting in a manner likely to endanger that person's own safety or the safety of others, the police officer may apprehend and immediately take the person to a physician for examination, which includes admission to a psychiatric facility for examination by a physician there. (*MHA*, s 28(1)).

2. Authority of a Provincial Court Judge

Anyone may apply to a Provincial Court judge to issue a warrant authorizing an individual's apprehension and conveyance to a mental health facility for a period not exceeding 48 hours. To grant this warrant, the judge must be satisfied that admission under section 22 is not appropriate, and that the applicant has reasonable grounds to believe that sections 22(3)(a)(ii) and (c) of the *MHA* describe the condition of the individual (*MHA*, s 28(4)).

C. *Application for Long-Term Admissions*

A person can be admitted to a facility by the director of a provincial health facility on receipt of two medical certificates (Form 4 under the *MHR*), each completed by a physician in accordance with section 22(2). The patient will be discharged one month after admittance unless the detention is renewed (Form 6 under the *MHR*) in accordance with section 24 of the *MHA*.

D. *Contents of Medical Certificates (MHA, s 22 (3))*

The certificates must contain:

1. A physician's statement that the individual was examined and that the physician believes the person has a mental disorder;
2. An explanation of the reasons for this opinion; and
3. A separate statement that the physician believes the individual requires medical treatment in a provincial mental health facility to prevent the person's substantial mental or physical deterioration, to protect the person, or to protect others, and that the individual cannot be suitably admitted as a voluntary patient.

For admission to be valid, the physician who examined the person must sign the medical certificate (Form 4) and must have examined the patient not more than 14 days prior to the date of admission. For a second medical certificate (Form 4) to be valid, it must be completed within 48 hours of the patient's admission. The *MHA* does not provide guidance about the type of examination required, nor does it require that the patient be informed of the purpose of the examination or that the examination is even being conducted. This practice has been the subject of a *Charter* challenge in the past, but the case was dismissed for other reasons (see *Levy*).

E. *Consent to Treatment*

Under section 31, a patient who is involuntarily detained under the *MHA* is deemed to consent to any treatment given with the authority of the director. This will override any decisions made by a patient's committee, personal guardian, temporary substitute decision maker, or representative.

An involuntary patient, or someone acting on their behalf, may request a second medical opinion on the appropriateness of the treatment authorized by the director. Under section 31(2), a patient may request a second opinion once during each detention period. Under section 31(3), upon receipt of the second medical opinion, the director need only consider whether changes should be made in the authorized treatment for the patient. Currently, this issue is the subject of a *Charter* challenge. A decision has yet to be made regarding the issue. Please refer to *MacLaren v British Columbia (Attorney General)*, 2018 BCSC 1753, and *British Columbia (Attorney General) v Council of Canadians with Disabilities*, 2022 SCC 27.

F. *Right to Treatment*

Section 8 of the *MHA* requires directors to ensure that patients are provided with "treatment appropriate to the patient's condition and appropriate to the function of the designated facility." However, what constitutes "appropriate treatment" is not clearly set out by the *MHA*, leaving the parameters uncertain. It is unclear what would constitute a failure to provide treatment, and whether a facility would be bound to discharge a patient should a failure be found.

A patient held without any treatment whatsoever may be able to claim civil damages on the basis of non-administration of treatment, constituting a breach of a statutory duty. Decisions regarding what amounts to appropriate treatment fall within the discretion of the institution. However, it is

important to note that the common law of medical malpractice applies to treatment administered in a mental health facility, thus imposing certain limitations on that discretionary power.

G. *Right to be Advised of One's Rights*

Pursuant to section 34 of the *MHA* and Form 13 under the *MHR*, directors must inform patients orally and in writing of their section 10 *Charter* rights and of the *MHA* provisions relating to duration, review, and renewal of detention; review hearings; deemed consent and requests for second opinions; and, finally, court applications for discharge. Directors are bound to ensure that patients are able to understand these rights.

British Columbia has also recently introduced legislation that will allow amendments to the *MHA* so that people involuntary admitted under the act will be given the option to meet with and access support from an independent rights advisor. This service is expected to be available in 2023 and will be delivered by a team of independent rights advisors who will provide information and answer questions regarding rights and obligations under the *MHA*.

H. *Transfer of Patients or Extended Leave*

Section 35 of the *MHA* gives the director authority to transfer a patient from one facility to another when the transfer is beneficial to the welfare of the patient. Under section 37, a patient may be given leave from the facility (no minimum or maximum periods are specified). Under section 38, a patient may also be transferred to an approved home under specific conditions.

A person released from a provincial mental health facility on leave or transferred to an approved home is still considered to be admitted to that facility and held subject to the same provisions of law as if they were continuing to reside at the mental health facility (*MHA*, s 39(1)). The patient is still detained under the *MHA* and will be subjected to treatment authorized by the director, which is still deemed to be given with the consent of the patient. If the conditions of the leave or transfer are not met, the patient may be recalled to the facility they are on leave or were transferred from, or they may be sent to another authorized facility (*MHA*, s 39(2)). There is no statutory obligation on the facility to inform the patient that the leave is conditional or has expired, raising the possibility that a patient may unknowingly violate the terms of their leave.

Under section 25(1.1), if a patient has been on leave or in an approved home for more than 12 consecutive months without a request for a review panel hearing, their treatment record must be reviewed by the Mental Health Review Board. If the Mental Health Review Board believes there is a reasonable likelihood that the patient could be discharged, a Review Panel must be conducted. In practice, however, the Review Panel ordinarily contacts the patient to ask if they would like a hearing.

I. *Discharge of Involuntary Patients*

1. *Through Normal Hospital Procedure*

The director may discharge or grant leave to a person from an institution at any time (*MHA*, ss 36(1) and 37). Under section 23, "a patient admitted under s 22 may be detained in a provincial mental health facility for one month after the date of their admission, and they shall be discharged at the end of that month unless the authority for their detention is renewed in accordance with s 24". A doctor must renew that authority for further periods of one month, then three months, and then six months.

2. *Through a Review Panel Hearing*

An involuntary patient is entitled to a Review Panel hearing before a Mental Health Review Board (MHRB). Generally, a patient is entitled to one hearing during each period of involuntary detention. The application for a Review Panel hearing may be made by the patient or by someone acting on the patient's behalf (*MHA*, s 25). The application is completed by filling out an "Application for Review Panel" (Form 7 under the *MHR*), Section 6 of the *MHR* sets out the requirements for scheduling a Review Panel hearing.

A Review Panel hearing takes place before a MHRB panel of three people, which must include a medical practitioner, a member in good standing with the Law Society of British Columbia (or a person with equivalent training), and a person who is not a medical practitioner or a lawyer. Under the *MHA*, the Minister appoints the Chair and all the legal, medical, and community members authorized to sit as MHRB members. The Chair serves full-time, and the members serve part-time. The Chair appoints three members for each Review Panel hearing from the list of people previously chosen by the Minister.

In order to maintain a quasi-judicial character, it is policy that those who sit on the MHRB do not have access to the patient prior to the hearing. Decisions are based on evidence and testimony presented at the hearing only. Section 24.3 of the *MHA* gives the MHRB the power to compel witnesses and order disclosure of information.

The hospital's position is usually presented by another medical practitioner acting as the hospital's representative; this practitioner is ordinarily the involuntarily detained person's attending psychiatrist. The involuntary patient has a right to representation by a lawyer or trained legal advocate who can present the patient's position at the hearing.

The MHRB members generally rely on the hospital presenter and the patient's counsel to provide documents and evidence during the Review Panel hearing. However, the MHRB may order disclosure of records that are relevant to making a decision. Procedure at review panel hearings is subject to the principles of fundamental justice under section 7 of the *Charter* and to due process under the common law, as well as the provisions of the *Administrative Tribunals Act* listed under section 24.2 of the *MHA*.

The Mental Health Review Board (MHRB) has also developed MHRB Rules of Practice and Procedures, and Practice Directions, which are available on the MHRB website: https://bcmhrb.ca.

a) *Patients' Rights at Review Panel Hearings*

The patient may retain counsel for representation at the hearing. This representative need not be a lawyer. Representation at a panel is provided free of charge by CLAS' Mental Health Law Program within the lower mainland or on an *ad hoc* basis outside of the lower mainland (see **Section II.B.2: Resources** for contact information).

The fundamental principles of justice dictate that one has a right to appear at one's own hearing. However, under section 25(2.6) of the *MHA*, the chair of the Review Panel may exclude the patient from the hearing or any part of it if they are satisfied that exclusion is in the patient's best interests. This power is rarely exercised; when it is, it is often done in accordance with the patient's wishes, as Review Hearings may cause a lot of distress. The patient or counsel can call witnesses to give evidence in support of the patient's argument for discharge.

Presumptively, patients also have the right to access all documents regarding their hearing prior to the hearing. For self-represented patients, under *Rule 15* of the *Mental Health Review Board Rules of Practice and Procedure*, the facility must provide the patient adequate time and an appropriate location for document review prior to the hearing. Facilities also have an obligation to provide all disclosure in its possession as early as possible and no later than 24 hours prior to the hearing.

Within 48 hours of the hearing, the Review Panel must decide (by majority vote) whether the patient's involuntary detention should continue. Decisions must be in writing. Reasons must be provided no later than 14 days after the hearing. Section 25(2.9) of the *MHA* compels the panel to deliver a copy of the decision without delay to the mental health facility's director as well as to the patient or their counsel. If the decision is that the patient be discharged, the director must immediately serve a copy of the decision on the patient and discharge them.

b) What the Review Panel Must Consider

Under section 25(2) of the *MHA*, the Review Panel is authorized to determine whether the detention of the patient should continue. The patient's detention must continue if sections 22(3)(a)(ii) and (c) continue to describe the patient. Section 22(3)(a)(ii) requires that the person or patient is a person with a mental disorder. The *MHA* defines a person with a mental disorder as a person who has a disorder of the mind that requires treatment and seriously impairs the person's ability to either react appropriately to the person's environment or to associate with others. Section 22(3)(c) adds three more criteria that are required for involuntary patient status. That is, the patient is a person with a mental disorder who

(i) Requires treatment in or through a designated facility,
(ii) Requires care, supervision and control in or through a designated facility to prevent the person's or patient's substantial mental or physical deterioration or for the protection of the person or patient or the protection of others, and
(iii) Cannot suitably be admitted as a voluntary patient.

A Review Panel hearing must be conducted notwithstanding any defects in authority (Form 4 and Form 6) for the initial or renewed detention pursuant to section 22 of the *MHA*.

The Review Panel must consider the past history of the patient, including their past history of compliance with treatment plans. The panel must assess whether there is a significant risk that the patient will not comply with treatment prescribed by the director. Presumably, if the panel concludes that there is a significant risk that the patient will not comply with the director's treatment plan, it is open to them to conclude that sections 22(3)(a)(ii) and (c) continue to describe the patient. Again, the *MHA* amendments have made the criteria for detention broader, and it seems likely that it is more difficult for patients to end their detention under the *MHA*.

The BC Supreme Court recently held that the Review Panel board members have an obligation to determine whether or not the legal criteria to be an involuntary patient are met at the time of the hearing, not whether they were ever seriously impaired at some point in the past (see *Tizvar v British Columbia (Mental Health Review Board)*, 2021 BCSC 1680). This decision thus affects the interpretation of the serious impairment criteria whether a person is 'seriously impaired' by the mental disorder—by clarifying that the assessment of whether or not one is

seriously impaired should occur at the time of the hearing. This judicial review decision was vital as prolonged detention under the *MHA* on the basis that one met the criteria for involuntary patient status instead of their current condition, could have disturbing results.

3. *Through Court Proceedings*

A person may apply to the Supreme Court for a writ of *habeas corpus,* which is a writ requiring a detained person to be brought before a court to evaluate the lawfulness of the involuntary detention based on the documents used to support the detention. This is most suitable where there were procedural defects in the patient's admission or defects in the involuntary detention certificates (Form 4 and Form 6 under the *MHR*). *AH v Fraser Health Authority*, 2019 BCSC 227, discussed above, is an example of a case involving a writ of *habeas corpus*. If the Court finds that the detaining authority did not adhere to the statutory requirements for involuntary detention, this may constitute grounds for an action in false imprisonment and civil battery for unauthorized treatment, and the patient may be entitled to an award of damages (*Ketchum v Hislop* (1984), 54 BCLR 327 (SC)).

Under section 33 of the *MHA*, a request can be made to the Supreme Court for an order prohibiting admission or directing the discharge of an individual. This request may be made by a person or patient whose application for admission to a mental health facility is made under section 20(1)(a)(ii) or section 22, by a near relative of a person or patient, or by anyone who believes that there is not sufficient reason for the admission or detention of an individual.

Legal Aid BC and Access Pro Bono may be available for *habeas corpus* applications, section 33 applications under the *MHA*, and applications for judicial review of Mental Health Review Board hearing decisions. Please see the Advocacy Resources section beginning on page 3 for more details.

J. *Escapes from Involuntary Detention*

1. *Apprehension without a Warrant*

A patient detained involuntarily in a mental health facility who leaves the facility without authorization is, within 48 hours of escape, liable to apprehension notwithstanding that there has been no warrant issued (*MHA*, s 41).

2. *Warrant Constituting Authority for Apprehension*

Where a person involuntarily detained has been absent from a mental health facility without authorization, the director of the facility may, within 60 days, issue a warrant for apprehension; this warrant serves as authority for the apprehension and conveyance of the person back to the facility (*MHA*, s 41(1)).

3. *Patient Considered Discharged After 60 Days*

A patient is deemed to have been discharged if they have been absent from the facility for over 60 days without the issuance of a warrant (*MHA*, s 41(3)). However, if the patient is "charged with an offence or liable to imprisonment or considered by the director to be dangerous to [themselves] or others," the person is not deemed discharged and a warrant may still be issued.

4. Aiding Escapees

Under section 17 of the *MHA*, any person who helps an individual leave or attempt to leave a mental health facility without proper authority, or who does or omits to do any act that assists a person in so leaving or attempting to leave, or who incites or counsels a patient to leave without proper authority, commits an offence under the *Offence Act*, RSBC 1996, c 338.

VIII. MENTAL HEALTH ACT AND YOUTH

The provisions for voluntary and involuntary detention under the *MHA* apply identically to adults and children ages 16 or older. Children 16 and older may request admission to a mental health facility and, if a physician finds that they have a mental disorder, they can be voluntarily admitted; they may also be discharged at their own request (*MHA* s 20(6)(b)).

A child over the age of 16 may be involuntarily admitted to a mental health facility when they meet the criteria set out under section 22 of the *MHA*. Please see section **VII: Mental Health Act: Involuntarily Admitted Patients** for the requirements for admission as an involuntary patient.

There are special provisions under the *MHA* for voluntary and involuntary admission of children under the age of 16 to mental health facilities.

For plain language descriptions of voluntary and involuntary detention for youth, and for further information regarding the impact of the *Mental Health Act* on youth, please review the 2021 report issued by the Representative for Children and Youth, entitled "Detained: Rights of children and youth under the *Mental Health Act*".

A. Involuntary Admission of Youth

Children under the age of 16 can be admitted to a mental health facility via the same provisions that permit detention of adults. Children under 16 who are involuntarily detained have the same right to receive notice (*MHA* s 34.1). The child must be informed both orally and in writing of the name and location of the facility they have been admitted to, their rights under section 10 of the *Charter*, and the provisions of sections 21, 25, 31, and 33 of the *MHA*.

Section 21 of the *MHA* advises the child that if they request to leave the facility, they are entitled to a hearing by review panel within the statutorily mandated time frames to determine whether their detention should continue. The process of a hearing by review panel is described under section 25 of the *MHA*. Section 31 advises the child that treatment authorized by the director is deemed to be given with the consent of the patient, that they may request a second medical opinion on the appropriateness of their treatment once in each detention period, and that the director must consider whether the second opinion merits changes to the authorized treatment. Section 33 notifies the child that they can apply to the court for a discharge and explains how this action would proceed.

The above mentioned report released by the Representative for Children and Youth highlights that children detained under the *MHA* feel unheard and uninformed in spite of the obligation to inform children of their rights and in spite of the procedures for reviewing their detention. An investigation by CLAS was cited in support of the view that health care providers have inadequate education, training, and time to advise children of their rights (Community Legal Assistance Society, Operating in Darkness: BC's Mental Health Act Detention System (Vancouver, 2017), 67), and that this has significant consequences for children involuntarily detained under the *Act*. Children face significant barriers to exercising their rights, including barriers to accessing legal representation.

B. Voluntary Admission of Youth

Children under the age of 16 can be admitted to a mental health facility under the same provisions that permit voluntary detention of adults. However, there is another way for youth to be "voluntarily" admitted to a health facility. At the request of a parent or guardian, a child can be admitted to a mental health facility on a voluntary basis if the examining physician determines that the child has a mental disorder (*MHA* s. 20). This is considered a voluntary detention because parents have the legal right to make decisions on behalf of their children; however, this does not mean that the detention is considered voluntary by the child. Because the parents consented to the detention

on behalf of the child, they are also able to remove the child at any time. If a parent or guardian requests that the child be discharged, the request must be followed unless the director is satisfied that the child meets the conditions for involuntarily admitting a patient over the age of 16.

The "deemed consent to treatment" provision under section 31 of the *MHA* does not apply to children who are detained at the request of their parents. Consent must come from the child's parents unless the child is considered a mature minor with the capacity to engage in their own decision-making. A mature minor is a child under the age of 16 who has been found to have legal capacity and the right to decision-making autonomy commensurate with their intelligence and maturity (*A.C. v. Manitoba (Director of Child and Family Services),* 2009 SCC 30). Children who are mature minors have the authority to consent to their own treatments. Their right to consent cannot be overridden by the parent or guardian, medical team, or the director without a court order. The *Infants Act* allows doctors to attain consent from mature minors who understand the nature and consequences of a given treatment as well as its potential risks.

In a way, this provides children with more protection than those over the age of 16. Rather than being subjected to the "deemed consent" treatments required by the director, which prevent adults from having a decision-maker act on their behalf, parents are able to consent to treatments on behalf of the child. Alternatively, children who are considered mature minors may consent to their own treatments.

However, this pathway to detention in a mental health facility raises the concern that the detention is not truly voluntary, even if it is voluntary in name due to consent by the parents, because the patient themselves has not consented or voluntarily admitted themselves.

IX. THE CRIMINAL CODE

A. Fitness to Stand Trial

An accused is presumed fit to stand trial until the contrary is proven on a balance of probabilities (*Criminal Code*, s 672.22). The burden of proof is on whoever raises the issue, either the accused or Crown counsel, (*Criminal Code*, s 672.23(2)).

An accused is deemed "unfit to stand trial" under section 2 of the *Criminal Code* if they are incapable of understanding the nature, object, and possible consequences of the criminal proceedings, or if they are unable to communicate with counsel on account of mental illness. If the court reaches the verdict is that the accused is unfit to stand trial, any plea that has been made will be set aside and the jury will be discharged (*Criminal Code*, s 672.31). Under section 672.32, the accused may stand trial once they are fit to do so. For a detailed outline of the tests for fitness, see *R v Taylor* (1992), 77 CCC (3d) 551.

The court may order a trial (not an assessment) on the issue of the accused's fitness to stand trial at any stage in the proceedings prior to a verdict, either on its own motion or on an application of either the prosecution or the defence (*Criminal Code*, s 672.23).

If a person is found unfit to stand trial, they may be detained in a mental health facility until they recover enough to proceed with the trial (*Criminal Code*, s 672.58). However, the court cannot make a disposition order to have an accused detained in a health facility without the consent of the hospital or a treating physician (*Criminal Code*, s 672.62(1)). A recent Supreme Court of Canada case, *R v Conception*, 2014 SCC 60, confirmed the need for such consent (at para 3). The court found that "[t]he hospital consent was required for the disposition order in its entirety, and not simply the treatment aspects of it." The exception to this is the rare case in which a delay in treatment would breach the accused's rights under the *Charter*, and an order for immediate treatment is an appropriate and just remedy for that breach. An inquiry by the court must be held no later than two years after the verdict of "unfit" and every two years afterward. The court may now extend the period for holding an inquiry where it is satisfied that such an extension is necessary to determine whether sufficient evidence can be adduced to put the person on trial (*Criminal Code*, s 672.33).

After the court deems a person unfit to stand trial, a disposition hearing must be held by the Review Board within 45 days, taking into account the safety of the public and the condition and needs of the accused. While the term in section 672.54 "least onerous and least restrictive" has been replaced by "necessary and appropriate", the intent of the legislation has not changed, as explained below in ***C. Disposition Hearings after NCRMD***.

The BC Court of Appeal considered a Review Board decision regarding custody in a fitness case; *Evers v British Columbia (Adult Forensic Psychiatric Services),* 2009 BCCA 560. The BCAA stated that the Review Board erred in proceeding with a disposition hearing in the absence of the accused without first attempting to ensure the accused's presence by issuing a warrant or allowing a short adjournment. Further, the court stated that fear of non-compliance with medical treatment cannot be the main objective motivating a custody disposition order, nor can the Review Board impose treatment as a condition on the accused.

In *R v Demers*, 2004 SCC 46, the court found that the former sections 672.33, 672.54, and 672.81(1) violated the *Charter* rights of permanently unfit, non-dangerous accused persons. The court wanted to ensure that an accused found unfit will not be detained unnecessarily when they pose no risk to the public. Pursuant to this decision, these sections have been amended.

A Review Board may now make a recommendation to the court to enter a stay of proceedings if it has held a hearing and is of the opinion that the accused remains chronically unfit and does not pose

a significant threat to public safety. Notice of intent to make such a recommendation must be given to all parties with a substantial interest in the proceedings (*Criminal Code*, s 672.851).

The Review Board, the prosecutor, or the accused may apply for an order of assessment of the accused's mental condition, if necessary, to make a recommendation for a stay of proceedings, or to make a disposition if no recent assessment has been made (*Criminal Code*, s 672.121). A medical practitioner or any person designated by the Attorney General may also make an assessment. An assessment order cannot be used to detain an accused in custody unless it is necessary to assess the accused, or unless the accused is already in custody, or it is otherwise required.

An appeal from an order for a stay of proceedings may be allowed if the Court of Appeal finds the assessment order unreasonable or unsupported by evidence.

A recent case (*R v JJG*, 2014 BCSC 2497 at paras 17-27) considered the issue of whether statements made by an accused during the fitness to stand trial hearing are admissible in the trial. In this case, the accused made an admission of guilt during the fitness hearing. The court ruled that the statements were inadmissible at trial.

B. Criminal Responsibility

1. Defence of Mental Disorder – Criminal Code, Section 16

An accused may be found "Not Criminally Responsible on account of a Mental Disorder" (NCRMD) if an accused is found to have been suffering from a mental illness at the time of the offence which resulted in either:

- a lack of appreciation of the nature and quality of the offence (i.e. they could not foresee and measure the physical consequences of the act or omission) (*R v Cooper*, [1980] 1 SCR. 1149; or
- a failure to realize that the act or omission was wrong (i.e. they did not know it was something that one should not do for moral or legal reasons (*Chaulk v The Queen* (1990), 3 SCR 1303);

This is a verdict distinct from either guilty or not guilty. If an accused is found NCRMD, the court can decide whether the accused will receive an absolute discharge, a conditional discharge, or a custody disposition to be detained in a psychiatric hospital. Alternatively, and more often in practice, the court can defer this decision to the provincial Review Board designated under section 672.38 of the *Criminal Code*. If the accused is not found to be a significant threat to public safety (discussed below), they must be given an absolute discharge.

When addressing the matter of the accused's mental capacity for criminal responsibility, the court has much the same power to order an assessment to obtain evidence on this question (*Criminal Code*, s 672.11(b)) as it does with respect to an accused's fitness to stand trial. Pre-trial detention of an accused while awaiting in-custody assessments was held to violate section 7 of the *Charter* by an Ontario court (*R v Hussein and Dwornik* (2004), 191 CCC (3d) 113 (OSCJ) [*Hussein*]). However, *Hussein* was not followed in a more recent Ontario case (*Her Majesty the Queen in Right of Ontario v Phaneuf [Indexed as Ontario v Phaneuf]* 2010 ONCA 901 at para 19). The Ontario Court ruled that the relevant provisions in the *Criminal Code*, specifically s.672.11, cannot be interpreted as requiring accused individuals who are ordered to be assessed in custody in a hospital to be taken immediately to that hospital. It cannot be read as prohibiting their detainment in a detention centre pending transfer to the hospital. Accordingly, it was held that *Hussein* was wrongly decided.

The accused is always entitled to raise a lack of mental capacity when facing criminal liability by calling evidence relating to it. The Crown may adduce evidence on the accused's mental capacity for criminal responsibility where the accused has raised the issue or has attempted to raise a reasonable doubt using a defence of non-mental disorder automatism (a mental state lacking the voluntariness to commit the crime). Where the accused pleads not guilty, does not put mental capacity in issue, and does not raise the defence of non-mental disorder automatism, the court may allow the Crown to adduce evidence on the issue of mental capacity only after it has been determined that the accused committed the act or omission (*R v Swain,* [1991] 1 SCR 933).

An accused is presumed to not suffer from a mental disorder that exempts them from criminal responsibility until the contrary is proven on a balance of probabilities (*Criminal Code*, s 16(2)). An official finding that the accused is NCRMD will only occur when the Crown has otherwise proven the guilt of the accused beyond a reasonable doubt, and when the mental disorder exempting the accused from criminal responsibility is proven on a balance of probabilities. The burden of proof is on the party that raises the issue (*Criminal Code*, s 16(3)).

C. *Disposition Hearings After NCRMD*

A finding of NCRMD ends criminal proceedings against the accused. There will then be a disposition hearing either in court or before the Review Board (*Criminal Code*, s 672.38). Under section 672.54, a person found NCRMD may be:

a) discharged absolutely where the Review Board or court finds that the accused is not a significant threat to the safety of the public;
b) discharged subject to conditions considered appropriate by the court or Review Board; or
c) detained in custody in a psychiatric hospital subject to conditions considered appropriate by the court or Review Board.

With the passage of Bill C-14 in 2014, discussed fully below, the court may also designate a person as a high-risk accused, and then the Review Board would only be able to make a narrow custody order. The amendments flowing from Bill C-14 have also changed other sections of the Mental Disorder provisions of the *Criminal Code*, some of which are highlighted below.

Bill C-14, or the *Not Criminally Responsible Reform Act*, SC 2014, c 6 [*NCRRA]*, came into force on July 11, 2014. This legislation was intended to strengthen the *Criminal Code's* decision-making process relating to findings of NCRMD, and thereby make public safety the primary consideration, enhance victim safety, and provide victims with a stronger voice in the process.

The primary function of the amendments was to create a new designation of "high-risk accused". Section 672.64 of the *Criminal Code* allows the court to designate a person who was found NCRMD to also be a high-risk accused. This designation is available when the offence is a serious personal injury offence, as defined in section 672.81(1.3), committed by an accused who was over 18 at the time of the offence. One of two additional factors must also be present. The first of these factors is a finding by the court that there is a substantial likelihood that the accused will use violence that could endanger the life or safety of another person. The second factor is a finding by the court that the acts underlying the offence were of a brutal nature, indicating a risk of grave physical or psychological harm to another person.

When deciding whether to render this designation, the court considers the factors outlined in section 672.64(2) of the *Criminal Code*. These factors include the nature of the offence, the accused's current mental state, any patterns of offence-related conduct, and expert opinion. Once a person is found to be a "high-risk accused", they are subject to mandatory hospital detention and may have increased time between Review Board hearings.

For the high-risk accused designation to be removed, the Review Board must first refer the finding to a superior court. The court may only revoke the designation if satisfied that there is not a substantial likelihood that the accused will use violence that could endanger the life or safety of another person.

Bill C-14 also aimed to improve victim's rights, by providing notice to victims of the intended residence of any NCRMD accused who receives an absolute or conditional discharge. The victim is informed of the general location where the offender resides, but not the specific address. Furthermore, when the high-risk status of an accused is under review by the court, victims may file impact statements which must then be considered by the court.

Significant criticism has been directed at these provisions prior to their coming into force, suggesting that they will do little to improve the rights and safety of victims and that they are unnecessarily punitive in nature. It has been argued that by placing the "high-risk" designation in the hands of the courts, the ability for the Review Board and hospitals to appropriately assist, treat and manage NCMRD patients will be diminished. For a full discussion of these concerns, see Lisa Grantham's "Bill C-14: A Step Backwards for the Rights of Mentally Disordered Offenders in the Canadian Criminal Justice System". Despite the criticisms directed at Bill C-14 there have not been any significant changes to the Review Board or its authority since the new provisions came into force.

In British Columbia, there is no person currently designated as a "high-risk accused". The only BC case involving a determination of "high-risk accused" status is *R v Schoenborn,* 2010 BCSC 220 [*Schoenborn*]. The accused was found NCRMD and was held in a mental health facility. In April 2015, the BC Review Board granted Schoenborn escorted community access at the discretion of the Director of the facility to aid his rehabilitation. In 2017, the Attorney General of BC applied unsuccessfully to the BC Supreme Court to have Schoenborn designated as a "high-risk accused". After many days of evidence in court, the judge found that Schoenborn did not meet the criteria for a "high risk accused" (*R v Schoenborn*, 2017 BCSC 1556).

There is some discrepancy between the provinces as to whether the "high-risk accused" designation can be applied retroactively. In British Columbia, it has been found that applying a retroactive "high risk" designation to trials that occurred before the legislation came into effect is not unconstitutional (*R v Schoenborn* 2015 BCSC 2254). However, Quebec courts made the opposite determination in 2015(see *R c CR*, 2015 QCCQ 2299).

When the Review Board renders a decision under section 672.54, it must consider "the need to protect the public from dangerous persons, the mental condition of the accused, the reintegration of the accused into society and the other needs of the accused." The 2014 Bill C-14 amendments have changed the wording from requiring the Review Board to make a decision that is "least onerous and least restrictive" to one that is "necessary and appropriate". However, subsequent Review Board decisions and court decisions have confirmed that the intent and guiding principles from the Supreme Court of Canada case of *Winko v British Columbia (Forensic Psychiatric Institute),* [1999] 2 SCR 625 [*Winko*] still apply. Therefore, the principle of making the least onerous and least restrictive order still applies to Review Board decisions. For further related case law please see *Ranieri (Re)* 2015 ONCA 444; *Re Osawe,* 2015 ONCA 280; *McAnuff (Re)* 2016 ONCA 280.

The Review Board must assess cases in which a person is found NCRMD at least once per year if the person is still detained in a mental facility or is fulfilling conditions pursuant to the disposition hearing (*Criminal Code*, s 672.81). However, as a result of the operation of section 672.54, it is possible for individuals found NCRMD to be subjected to prolonged or indeterminate detention or supervision by the Review Board, even for committing relatively minor offences.

In response to a number of cases challenging the constitutionality of section 672.54, the Supreme Court in *Winko* rejected arguments that section 672.54 violates the *Charter*. According to *Winko*, a

"significant risk to the safety of the public" means a real risk of physical or psychological harm to members of the public. The conduct giving rise to the harm must be criminal in nature. The process of determining whether the accused is a significant threat to public safety is non-adversarial, and the courts or Review Board may consider a broad range of evidence. This includes the accused's past and expected course of treatment, present medical condition, past offences, plans for the future, and any community supports that exist. See *Winko* for a detailed application of section 672.54. Bill C-14, discussed fully below, codifies some of this decision, such as the definition of "significant harm".

Two Supreme Court of Canada cases considered the "least onerous and least restrictive" requirement of s 672.54. In *Pinet v St Thomas Psychiatric Hospital*, 2004 SCC 21, it was held that the "least onerous and least restrictive" requirement applies not only to the bare choice among the three potential dispositions – absolute discharge, conditional discharge, or custody in a designated hospital—but also to the particular conditions forming part of that disposition. In *Penetanguishene Mental Health Centre v Ontario (Attorney General)*, 2004 SCC 20, the court decided that this applied not only to the choice of the order, but also to the choice of appropriate conditions attached to the order, consideration of public protection, and maximisation of the accused's liberties.

The Review Board's powers were considered in *Mazzei v BC (Director AFPS)*, 2006 SCC 7. It has the power to place binding orders and conditions on any party to the Review Board hearing, including the director of the psychiatric hospital. The Review Board does not prescribe or administer treatment, but it may supervise and require reconsideration of treatment provided. Treatment is incidental to the objectives and focus on public safety and reintegration, and the Review Board aids in only these two goals.

For information on pleading "Mental Disorder" and "Non-Mental Disorder" automatism, please consult the Continuing Legal Education Society's course "Criminal Law and Mental Health Issues".

X. COMPLAINTS TO THE OMBUDSPERSON

Complaints concerning provincial mental health facilities, their practices, or their treatment of patients may be taken to the BC Ombudsperson. This office has the authority to investigate patient complaints, make recommendations to the facility, mediate any problems arising between a patient and the facility, and to make recommendations to the Lieutenant-Governor and the Provincial Cabinet concerning the results of these investigations.

Complaints must be made in writing. The office is careful to ensure that, where necessary, the identity of the complainant is withheld from hospital staff. Common complaints include concerns about over-medication, seclusion, or providing information about patient rights. In such cases, the Ombudsperson has the authority to take the issue to an outside medical source to verify whether the patient is receiving appropriate levels of medication, to ensure the facility follows necessary protocols and reviews for placing people in seclusion and provides immediate rights information for those involuntarily detained. Complaints can be filed through the website at https://bcombudsperson.ca/or by calling the Ombudsperson's office at 1-800-567-3247.

Pursuant to investigating these complaints, in March of 2019, the Office of the Ombudsperson released a report titled "Committed to Change: Protecting the Rights of Involuntary Patients under the *Mental Health Act*". This report investigated many complaints alleging that the legislative safeguards outlined above were not followed. The report states that the Office was "disappointed to find significant levels of non-compliance" when reviewing the forms. "In many cases, forms were simply not completed. In many other cases, the forms were completed late or in a manner that did not provide anything close to adequate reasons" (p 6).

The report includes the office's methodology, findings, and recommendations, and it can be accessed at https://www.bcmhrb.ca/app/uploads/sites/431/2019/03/OMB-Committed-to-Change-FINAL-web.pdf.

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XII. LSLAP FILE ADMINISTRATION POLICY – MENTAL HEALTH

This section is specific to LSLAP clinicians. It sets out internal LSLAP practice and policy regarding Mental Health. Students with clients who have upcoming review panel hearings are encouraged to contact the Mental Health Law Program at CLAS for advice and to determine whether a referral would be appropriate. The Mental Health Law Program (MHLP) at CLAS assists involuntarily admitted patients at review panel hearings.